Repositioning Centers of Excellence for an Accountable Care World

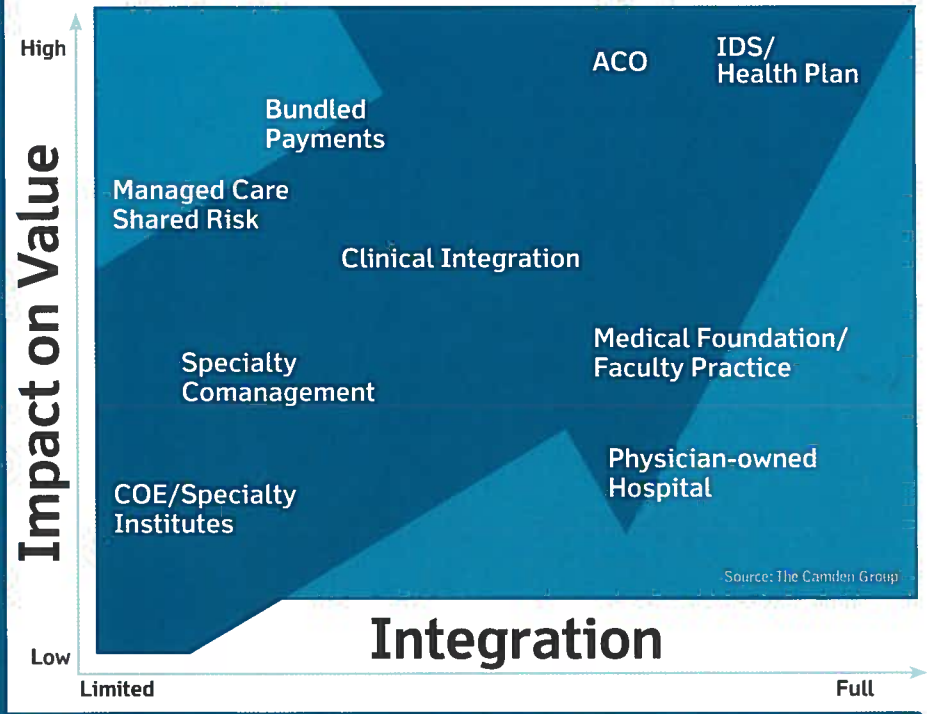
Centers of excellence can serve as a bridge from the fee-for-service business model to a new business model based on global and value-based payment.

Since the passage of healthcare reform, there has been a lot of discussion and much ink spilled on preparing for accountable care organizations (ACOs) and value-based purchasing. For most organizations, the magnitude of the change required to convert from a fee-for-service philosophy and business model to a business model based on global payments and value is daunting. How does an organization move from one paradigm to the next without jeopardizing its success in the interim?

Service lines can be an ideal bridge to this change. For decades, hospitals and health systems have focused on building centers of excellence to attract patients and skilled physicians to their facilities. Many resources have been dedicated to improving service line performance, including program development, marketing and branding campaigns, and strengthening affiliations with physicians. In many organizations, building blocks that can be used to bridge to value-based purchasing are already present in well-developed service lines. The learnings from the service lines can then be applied to the overall organization in an accountable care world.

Although an organization can take different paths on the road from fee-for-service to fee-for-value and accountable care, development and alignment of a physician base is critical to the success of all of them (Figure 1). This article will focus on a few specific service line strategies that will move an organization down the road to delivering accountable care.

Figure 1. Physician-Hospital Integration: Driving the Value Proposition



Bundled Payments

The Center for Medicare & Medicaid Innovation (CMMI), a branch of the Centers for Medicare & Medicaid Services (CMS), recently announced the national expansion of the Bundled Payments for Care Improvement initiative, to be effective in 2012. Building on the success of the current ACE (Acute Care Episode) demonstrations—which CMS believes have resulted in more than $42 million in savings to CMS, $7 million in co-insurance savings, and significant quality improvement at the current five demonstration sites—CMS has offered potential sponsors of a bundled payment arrangement four models from which to approach implementation (Table 1). All four models require a minimum discount to CMS, and all allow gain sharing with physicians. Total physician payments, including professional fees and gain sharing, cannot exceed 150 percent of the Medicare fee schedule.

Model 4 is a prospective payment arrangement that can closely mirror the current ACE demonstration in any grouping of DRGs. Under Model 4, CMS would make a single, prospective bundled payment that would encompass all services furnished by the hospital, physicians, and other practitioners during an inpatient stay. This model could be defined around a service line.

These programs have the potential to drive market consolidation if one or a few providers are chosen in each market. As with the current ACE demonstration, rigorous quality and performance measurement is required to qualify and must be maintained and routinely reported to CMS. This rapid expansion of the bundled payment concept—providers could submit letters of intent to participate as early as October 6, 2011—signals CMS's intent to achieve Medicare savings from a number of different approaches, from Pioneer ACO concepts, shared savings programs, medical home demonstration projects, and now a national expansion of bundled payment. Many observers believe the demise of the Medicare fee-for-service payment system

Table 1. CMS's Four Bundled Payment Models

Model and Feature	Model 1 Inpatient Stay Only	Model 2 Inpatient Stay plus Postdischarge Services	Model 3 Postdischarge Services	Model 4 Inpatient Stay Only
Payment of Bundle and Target Price	• Discounted IPPS payment; no separate target price	• Retrospective comparison of target price and actual FFS payments	• Retrospective comparison of target price and actual FFS payments	• Prospective set payment
Clinical Conditions Targeted	• All MS-DRGs	• Applicants to propose based on MS-DRG for inpatient hospital stay	• Applicants to propose based on MS-DRG for inpatient hospital stay	• Applicants to propose based on MS-DRG for inpatient hospital stay
Expected Discount Provided to Medicare	• To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first six months to 2% in year three	• To be proposed by applicant; CMS requires a minimum discount of 3% for 30–89 days postdischarge episode; 2% for 90 days or longer episode	• To be proposed by applicant	• To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration
Payments from CMS to Providers	• Acute care hospital: IPPS payment less predetermined discount • Physician: Traditional fee schedule payment (not included in episode)	• Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	• Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	• Prospectively established bundled payment to admitting hospitals; hospitals distribute payments from bundled payment

Source: Center for Medicare & Medicaid Innovation

could come as early as 2019.

Most acute care providers that see even modest volumes of Medicare patients are scrambling to ensure they are not left behind in the wake of this substantial payment reform, given that the risk of not participating is substantially decreased Medicare volumes in the future. Balancing the steep discounts Medicare is expecting against the risk of undertaking the physician fee (as in Model 4) and preventing readmissions is a tough financial task for acute care providers to manage.

Piloting these changes on a well-developed service line can mitigate an organization's risk while implementing needed tools for future success. Enhancing and positioning service lines to eliminate variation and provide consistent, cost-effective, high-quality care is a great stepping stone toward providing accountable care.

Comanagement

To establish a foothold toward true care redesign, many acute providers are engaging and involving their physicians through comanagement arrangements. Comanagement agreements allow groups of incorporated physicians and hospitals to share (or cede) authority and responsibility in given clinical areas to bring greater efficiency and higher levels of clinical quality. At the simplest level, these agreements are generally set up through a management contract, but they can be more complex structures that go beyond a service line to involve broader areas of the hospital.

Hospitals look to their physician management company partners to assume any combination of responsibilities, which could include employees, supplies, capital equipment, medical direction, and management (subject to compliance with Stark IV rules), with the aim of sharing savings and improving quality continuously until best practice is realized. The goals thereafter are to hold the gain.

Although comanagement is not the final stage in the clinical integration journey, it is an important step that can begin to demonstrate business and clinical success through collaboration. Trust is gained, and more can be accomplished later using other models.

Getting Started

So, where does an organization begin? Here is a checklist for getting started on repositioning service lines for an accountable care world.

- Honestly assess the service lines in terms of what is critical in the new environment.
- Prioritize the organization's focus.
- Identify and develop physician leadership.
- Implement structures that give responsibility and incentives to physicians for the management of patient care and overall performance of the service line. This may include comanagement agreements or physician employment with performance-based compensation.
- Negotiate with payers for compensation structures that align financial incentives, such as bundled payments, gain sharing, and shared savings.
- Standardize the care process and protocols.
- Eliminate silos and focus on the continuum of care.
- Redefine the role of the service line leader.
- Leverage information technology (IT).
- Create a culture of continuous improvement.

Written by:

Barbra Z. Riegel, Vice President
Robert A. Minkin, Senior Vice President